

APPENDIX L COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The following is a listing of preventive services for which payments will be made by the health plans.

For Adults:

The following are services for which payment will be made by health plans as separate medical services, as components of separate medical services, or as components of the “evaluation and management” services rendered by the health plans’ providers. The services and periodicity are adapted from the 1996 U.S. Preventive Services Task Force.

Screening:

1. Blood Pressure Measurement:

Minimum: single measurement; all ages and sex

Periodicity: every 2 years if normal
(on basis of expert opinion) every 1 year or more frequently if abnormal

2. Weight/Height Measurement:

Minimum: all ages and sex; single measurement

Periodicity: (on basis of expert opinion) every 2 years

3. Total Cholesterol Measurement:

Minimum: females age 45-65; single measurement
males 35-65; single measurement

Periodicity: every 5 years
(there is insufficient evidence to recommend cholesterol measurement in younger adults with high cardiovascular disease risk factors or in older adults, however recommendation for screening may be made on other grounds. See U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996)

4. Breast Cancer Screening:

age 50-69 Minimum: mammography alone or mammography and clinical breast exam (CBE)

Periodicity: annual

age 40-49: Although there is insufficient evidence to recommend either mammography alone or mammography and CBE, the American Cancer Society, the American College of OB/Gyn, and the American Academy of Family Physicians recommend mammography every 1-2 years and CBE every year and if done at this frequency, these screenings will be reimbursed by health plans.

age 70-74: Although there is insufficient evidence to recommend mammography screening, it will be reimbursed by health plans at the frequency of every 1 to 2 years.

5. Cervical Cancer Screening:

Minimum: pap test and pelvic exam; all sexually active women or age 18-65
Periodicity: annual, decreasing to every 3 years after 3 successive normal annual tests

Since it may be difficult to assess accurately if there have been 3 successive normal annual tests, annual pap tests will be reimbursed by Health plans.

6. Colorectal Cancer Screening:

Minimum: single sigmoidoscopy or annual fecal occult blood test (FOBT); age 50 or older
Periodicity: annual FOBT, sigmoidoscopy at age 50 and then every 10 years.

7. Prostate Cancer Screening:

Not recommended for routine screening.

If screening is to be performed, digital rectal exam and prostate specific antigen (PSA) for age 50-70 is best evaluated approach but should be preceded by objective information about the potential benefits and harms of early detection

8. Rubella serology or vaccination history:

Minimum: women of child bearing age

9. Tuberculin Skin Testing using the current methodology, schedule, and priority (immigrants, TB contacts, food handlers, health care and school workers, etc.) established by the DOH

10. Health Education and Counseling

1. substance use, including alcohol
2. diet and exercise
3. injury prevention
4. sexual behavior
5. dental health
6. family violence
7. depression: There is insufficient evidence to recommend for or against the routine use of standardized questionnaires to screen for depression in asymptomatic patients.
8. results and implications of screening listed above

Immunizations:

1. Tetanus-diphtheria (Td) booster
2. Rubella (or evidence of immunity) for women of child-bearing age
3. Hepatitis B in high risk groups--household and sexual contacts of HBsAg positive persons

Chemoprophylaxis:

1. Multivitamin with folic acid - pregnant women; women actively trying to become pregnancy
2. Counsel all peri and post menopausal women about the potential benefits and risks of hormone prophylaxis.

For the high risk population the required preventive interventions are an Adult Health Regimen which includes the prior listed preventive interventions in addition to the following:

<u>Risk Factor</u>	<u>Intervention</u>
1) low income; immigrants, alcoholics TB contacts	1) PPD
2) certain chronic medical conditions, institutionalized persons	2) PPD; pneumococcal vaccine influenza vaccine
3) health care/lab workers	3) PPD; hepatitis B and hepatitis A influenza vaccine
4) family h/o skin cancer; fair skin	4) avoid sun exposure
5) blood product recipients	5) HIV screen; hepatitis B vaccine
6) susceptible to measles, mumps, or varicella	6) MMR; varicella vaccine
7) previous pregnancy with neural tube defect	7) folic acid 4.0 mg
8) injection or street drug use	8) RPR/VDRL; PPD; HIV screen hepatitis B & A vaccine
9) high risk sexual behavior vaccines	9) STD screens; hepatitis B&A

For Pregnant Women:

The following are services for which payments will be made by the health plans as separate medical services, components of separate medical services or as components of the maternity (vaginal/Cesarean Section delivery; prenatal care, postpartum care) benefit.

1. **Prenatal laboratory screening tests**, including voluntary HIV testing and counseling and tests for alpha-fetoprotein alone or in combination with other tests to screen for neural tube anomalies and chromosomal anomalies such as Down's syndrome. Prenatal laboratory screening tests covered include testing for gestational diabetes, rubella, GC, syphilis, chlamydia, pap smear, Hepatitis B, Blood typing and RH, urinalysis, complete blood count, etc. as currently recommended by the American College of Obstetrics and Gynecology (ACOG).
2. **Prenatal visits** meeting the periodicity and standards currently recommended by the ACOG.
3. **Health education and Screening** for conditions which could make a pregnancy "high risk"--such as smoking, alcohol and other substance use, depression, inadequate diet, psychosocial problems, early signs of premature labor, other medical conditions, etc. and appropriate referrals including WIC and mental health providers. Other health education such as fetal development, breastfeeding, labor and delivery.
3. **Diagnosis of premature labor**
4. **Diagnostic amniocentesis, diagnostic ultrasound, fetal stress and non-stress testing.**
5. **Prenatal vitamins including folic acid.**
6. **Hospital stays** for up to 48 hours after vaginal delivery or 96 hours after cesarean section delivery for healthy women with uncomplicated deliveries and postpartum stays following current guidelines of the American Academy of Pediatrics (AAP) or ACOG.

For Children:

The following are services for which payments will be made by health plans as separate medical services, as components of separate medical services, or as components of the EPSDT comprehensive evaluation.

1. **Newborn Screening**--newborn hearing assessment, newborn laboratory screening--phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect.
2. **Hospital stays for normal, term, healthy newborns** up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines of the American Academy of Pediatrics (AAP) and American College of Obstetrics and Gynecology (ACOG).
3. **Other age appropriate laboratory screening tests** currently in effect as recommended by the American Academy of Pediatrics (AAP), the Centers for Disease Control (CDC), and/or required by Health Care Financing Administration (HCFA) for Medicaid recipients (examples, hemoglobin/hematocrit, blood lead level). Refer to HCFA State Medicaid Manual 5123.2, October 1993 for HCFA minimum standard for Lead screening (12 and 24 months).
4. **Screening to assess health status** to include age appropriate general physical and mental health, growth, development, and nutritional status. The periodicity schedule follows the AAP's Guidelines for Health Supervision currently in effect. Included but not limited to the following:
 - a. Initial/interval health history
 - b. Height/Weight/Head Circumference
 - c. Blood Pressure
 - d. Developmental Assessment using the Denver Developmental Screening Test or Development Inventory (MCDI), or any other acceptable method for developmental screening.
 - e. Behavioral Assessment (including screening for substance abuse for age 12+)
 - f. Vision Testing
 - g. Hearing/Language Testing; Audiometry
 - h. Physical Examination
5. **Tuberculin Skin Testing** using the methodology recommended by the DOH following a schedule recommended by the Hawaii Chapter, American Academy of Pediatrics.
6. **Immunizations** following the standards and schedule of the Advisory Committee on Immunization Practices (ACIP) and the DOH currently in effect.

7. **Age appropriate Dental referral and oral fluoride**
8. **Age appropriate Health Education** of child and/or parent including dietary counseling, injury prevention, child maturation/development, behavior management, dental care, sexuality, family violence, STD, HIV, pregnancy, and depression. Provisions for children aged 12 years and older to be able to discuss sensitive issues alone with the provider or designated staff.

APPENDIX M
DENTAL PROCEDURES WHICH ARE THE
RESPONSIBILITY OF THE MEDICAL PLANS

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07340	Vestibuloplasty - ridge extension
D/07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Tumors:
D/07440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor - lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms:
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue:
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	Surgical Incision:
D/07511	Incision and drainage of abscess-intra oral soft tissue-complicated
D/07520	Incision and drainage of abscess - extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction - producing foreign bodies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body

* HCPCS Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPSC or CDT-5 PROCEDURE CODE*	DESCRIPTION
	Treatment of Fractures - Simple:
D/07610	Maxilla - open reduction (teeth immobilized if present)
D/07620	Maxilla - closed reduction (teeth immobilized if present)
D/07630	Mandible - open reduction (teeth immobilized if present)
D/07640	Mandible - closed reduction (teeth immobilized if present)
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Alveolus - stabilization of teeth, open reduction, splinting
D/07680	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Treatment of Fractures - Compound:
D/07710	Maxilla - open reduction
D/07720	Maxilla - closed reduction
D/07730	Mandible - open reduction
D/07740	Mandible - closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus - stabilization of teeth open reduction, splinting
D/07780	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions:
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical discectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy - diagnosis, with our without biopsy

* HCPSC Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07873	Arthroscopy - surgical: lavage and lysis of adhesions
D/07874	Arthroscopy - surgical: disc repositioning and stabilization
D/07875	Arthroscopy - surgical: synovectomy
D/07876	Arthroscopy - surgical: discectomy
D/07877	Arthroscopy - surgical: debridement
D/07880	Occlusal - orthotic device, by report
	Other Oral Surgery - Repair of Traumatic Wounds:
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm
D/07920	Skin grafts (identify defect covered, location and type of graft)
	Other Repair Procedures:
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; includes obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (Maxilla - total)
D/07947	Le Fort I (Maxilla - segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft
D/07949	Le Fort II or Le Fort III - with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible - autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Sialodochoplasty
D/07983	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft - mandible or facial bones, by report

* HCPCS Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
	Adjunctive General Services:
D/09220	General anesthesia - first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or a note)
D/09221	General anesthesia - each additional 15 minutes
D/09420	Hospital calls (limitation: confinement must be approved; only under physician's request, no routine or follow-up visits)

* HCPCS Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

APPENDIX N

GUIDELINES FOR ONE MONTH WAITING PERIOD

The health plan may subject a new adult member to a one-month waiting period for services which are not covered by the Medicaid State Plan. Health plans shall not apply the waiting period to adult members who have a break in coverage of 60 days or less. The waiting period may be reapplied to the member if the break in coverage is more than 60 days. The waiting period cannot be applied to children below the age of 21. The plan also cannot impose the waiting period for a member who is changing plans due to the Annual Plan Change Period or other reasons as the recipient was continuously enrolled in the program. The DHS will provide the plan with plan change information for persons electing to change plans during the Annual Plan Change period.

Urgent care for medical and behavioral health problems including office visits and related services such as laboratory and x-ray services for diagnostic purposes, prescription drugs (includes new and renewals of prescription drugs) shall not be subject to the waiting period. Follow-up visits related to the urgent or emergent conditions should also not be subject to the waiting period.

Pre-natal care is considered to be urgent care and therefore, not subject to a waiting period. Termination of a pregnancy is also not subject to the waiting period.

APPENDIX O
SERVICES AND MISCELLANEOUS ITEMS
NOT COVERED BY THE HAWAII QUEST PROGRAM

1. Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil and powder, sanitary napkins, soaps, lip balm, band aids
2. Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items or furnishings
3. Experimental and/or investigational services, procedures, drugs, devices, and treatments; drugs not approved by the FDA, brand name drugs except single source drugs and brand name drugs when required by statute required
4. Gender reassignment - all medical, surgical, and/or psychiatric services and drugs, including hormones, needed for changing the sex of an individual
5. In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures; procedures and drugs to treat infertility or enhance fertilization
6. Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs)
7. Obesity treatment, weight loss programs; food, food supplements including prepared formulas, health foods
8. Cosmetic surgery or treatment - cosmetic rhinoplasties, reconstructive, or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniclectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification
9. Tuberculosis services when provided free to the general public
10. Hansen's Disease treatment or follow-up
11. Treatment of persons confined to public institutions
12. Penile and testicular prostheses and related services

13. Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and/or consortium
14. Routine foot care; treatment of flat feet
15. Swimming lessons, summer camp, gym membership and weight control classes and
16. Smoking cessation classes (medications for smoking cessation may be provided)
17. Stand-by services by stand-by physicians, telephone consultations, telephone calls, writing of prescriptions, stat charges
18. All medical and surgical procedures, therapies, supplies, drugs, equipment for the treatment of sexual dysfunction
19. Beds - lounge beds, bead beds, water beds, day beds; overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
20. Topical application of oxygen
21. Contact lenses for cosmetic purposes; bifocal contact lenses
22. Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia), trifocal lenses (except as a specific job requirement), spare glasses
23. Orthoptic training
24. Physical exams for employment when the patient is self-employed or as a requirement for continuing employment (i.e. truck and taxi drivers' licensing, other physical exams as a requirement for continual employment by the State or Federal Government, or by private business)
25. Physical exams and immunizations for travel - domestic or foreign
26. Physical exams, psychological evaluations and/or immunizations as a requirement for Hawaii or other states' drivers' licenses or for the purpose of securing life and other insurance policies or plans.
27. Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as a Medicaid benefit.

APPENDIX P HAWAII'S EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PERIODIC SCREENING GUIDELINES

Patient Name:		INFANCY										EARLY CHILDHOOD				LATE CHILDHOOD				ADOLESCENCE			
		1-30 DAYS	2 MOS	4 MOS	6 MOS	9 MOS	12 MOS	15 MOS	18 MOS	2 YRS	3 YRS	4 YRS	5 YRS	6 YRS	8 YRS	10 YRS	12 YRS	14 YRS	16 YRS	18 YRS	20 YRS		
Date of Birth:																							
Elements for Health Screening																							
Date of Assessment:																							
1. Initial/Interval Health History																							
2. Height																							
3. Weight																							
4. Head Circumference																							
5. Blood Pressure																							
6. Developmental/Behavioral Assessment																							
7. Vision Testing																							
8. Hearing/Language Testing																							
9. Audiogram																							
10. Physical Examination																							
11. Immunizations																							
12. Tuberculin Skin Testing																							
13. Lead Risk Assessment																							
14. Lead Level																							
15. Hemoglobin/Hematocrit																							
16. Other Lab Screens																							
17. Dental Screen/Referral																							
18. Fluoride																							
19. Health Education & Counseling																							
20. Completed By:																							

These are minimum guidelines. Providers should perform all non-shaded elements of the health screen for the appropriate age. If at any time other procedures, tests, etc., are medically indicated, the physician should perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be updated at the earliest possible times.

HAWAII'S EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PERIODIC SCREENING GUIDELINES

- 1 Record in chart
- 2,3,4 Plot on NCHS grid
- 5

Blood Pressure Guidelines	<u>AGE</u> 3yo 5yo 10yo 15yo	<u>SYSTOLIC</u> <u>50%</u> 95 97 110 116	<u>90%</u> 112 115 130 130	<u>DIASTOLIC mmHg</u> <u>50%</u> 64 65 70 70 <u>90%</u> 80 84 92 95
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- 6 Obtain relevant developmental/behavioral/school history: utilize age appropriate developmental screen (e.g., R-PDQ, ICMQ, CDI, DENVER II, ELM, HearKit, appraisal of young child--gross motor, fine motor, communication, self-help/self-care, socio-emotional, cognitive skill development; evaluation of school age child--attention skills, learning disability, peer relationships, psychological/psychiatric problems) and behavioral questionnaire/survey (e.g., Eyberg)
- 7

Vision Guidelines	<u>AGE</u> 2 weeks 2 months 4 months 6 months 9 months 18 months 4,6,8,10,12,14,16,18 years	<u>EXAM</u> appearance of eyes: red reflex appearance of eyes: red reflex corneal light reflex: alignment; follow object corneal light reflex: alignment; follow object corneal light reflex: alignment; follow object EOM: cover test EOM: cover test EOM: cover test visual acuity
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- 8

Hearing/Language Guidelines	<u>AGE</u> Birth 4-5 months 8 months 12 months 2 years 3 years 4 years	<u>HEARING MILESTONES</u> responds to loud noises turns to sound source imitates parent's sounds understands simple phrases <u>SPEECH MILESTONES</u> spontaneous speech using 2-3 word phrases consistently uses beginning consonants m,n,h,p,g,f,w readily understands with good grammar
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- 9 Perform audiogram testing or obtain results from alternate source, e.g. school, ENT 1,000; 2,000; 4,000 Hz at 20 DB both ears/25 DB to compensate for extraneous noise
- 10 Record in chart
- 11 Use most currently available recommendations of the Department of Health/Immunizations Practice Advisory Committee/Center for Disease Control/American Academy of Pediatrics
- 12 Test with Mantoux (PPD) preferred; but, Tine may be used up to 5 years. Any positive Tine must be followed up by the PPD. High risk (annual test): child born outside of US in developing country; child with medical condition which would increase TB risk (e.g., HIV, chemotherapy, diabetes, renal disease)
- 13 Perform verbal risk assessment
- 14

Blood Lead Level Guidelines	Low risk: High risk:	12 months, 24 months 6 months, then every 6 months until 2 consecutive levels are <10, then every year until 72 months
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- 15 Hemoglobin or Hematocrit for anemia screening
- 16 Other optional lab screen include: urinalysis/urine bacteria screen, sickle cell screen: G6PD screen
- 17 Perform oral exam: refer to dentist at 12 months and every 6 months thereafter
- 18 Prescribe supplemental fluoride therapy with or without multivitamins per recommendations American Academy of Pediatric Dentistry and the American Academy of Pediatrics: revised dosage schedule is pending
- 19 Provide age appropriate anticipatory guidance for general health, nutrition, development, safety, sexuality, parenting: may use American Academy of Pediatrics Guidelines for Health Supervision II (pending revision)

APPENDIX Q

INSTRUCTIONS DHS FORM 1147

LEVEL OF CARE (LOC) EVALUATION

Top of Form: Check the appropriate box for the evaluation – initial request for placement into either a nursing home or community-based program; annual review; or other review such as a review requested by the department’s contractor for evaluating and determining level of care.

1. **Patient Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Sex:** Self-explanatory
4. **Medicare:** Check the appropriate box indicating whether client has Medicare Part A and B and enter client’s Medicare I.D. number, if eligible for either Part A or B.
5. **Medicaid Eligible?:** Check “Yes” or “No” to indicate whether the client is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, write in “pending” for I.D.# and write in date applied.
6. **Present Address/Facility:** Identify facility name if patient is residing in a facility. If patient is at home, enter street address, city and zip code. Check appropriate box that best represents the patient’s “home.”
7. **Provider I.D. No.:** Enter the Medicaid Provider I.D. number.
8. **Attending Physician:** Enter the name of the attending physician, telephone and fax number.
9. **Contact Person:** Enter the name, telephone and fax numbers of the person able to provide additional information about the patient.
10. **Return Form:** Indicate how the form should be returned (i.e., fax or mail) and to whose attention. The form will NOT be mailed or faxed back with a cover sheet so information must be accurate.
11. **Referral Information:** Complete all sections for an initial request. If this is an annual or other review, skip this section.

- A. **Source(s) of Information:** Identify the source(s) of patient information received.
 - B. **Responsible Person:** Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.
 - C. **Language:** Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.
12. **Assessment Information:** Complete all sections.
- A. **Assessment Date:** Date the most current assessment was completed.
 - B. **Assessor's Name, Title, Signature, Phone and Fax Numbers:** A registered nurse (RN) or physician must perform the assessment. Enter the name, title and telephone and fax numbers of the assessor. The assessor must sign the form.
13. **Requesting:** Enter expected placement date into the facility or community program. Check all services that are being requested. If hospice services has been elected by the patient AND the services will be provided in a nursing facility, attach the appropriate hospice election form. Hospice services in other settings do not require an 1147 form.

Applications for any Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form.

Indicate whether counseling on the HCBS option was provided and by whom. If counseling was not provided, provide brief explanation.

Independent Living (IL) services are available to provide information, referral for services, peer counseling and advocacy for the patient. Contact Hawaii Centers for Independent Living (HCIL) for brochures and other information that can be offered to the patient.

14. **Medical Necessity/Level of Care Action:** Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

- 1. **Name:** Self-explanatory
- 2. **Birthdate:** Self-explanatory

3. **Functional Status Related to Health Conditions:** Complete all sections.

- A. **List significant current diagnosis(es):** List the main diagnosis(es) or medical conditions related to the person's need for long-term care.
- B. **Comatose:** If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.
- C. **Sections III Vision/Hearing/Speech through XIII Dressing and Personal Grooming:** Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

- D. **Section XIV. Total Points:** Add the points from each section to obtain total. Comatose patients are assigned 30 points.
- E. **Section XV. Medications/Treatments:** List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.
- F. **Section XVI. Additional Information Concerning Patient's Functional Status:** Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required.

4. **Skilled Procedures:** For each type of nursing care, indicate whether the patient requires the particular care. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

5. **Social Situation:**

- A. **Person can return home:** Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. If the person does not have a home,

indicate whether the patient can be placed in a residential setting such as an Extended ARCH, assisted living facility or RACCP home.

- B. **Caregiving support:** If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.
 - C. **Caregiver name.** Provide the caregiver's name, relationship, address and phone numbers.
6. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the patient's nursing requirements or social situation.

Physician's Signature: Self-explanatory.

Date: Date that physician signs the form.

Physician's Name: Self-explanatory.

STATE OF HAWAII
Level of Care (LOC) Evaluation

Please Type

☐ Initial Request

☐ Annual Review

☐ Other review

1. PATIENT NAME (Last, First, M.I.)		2. BIRTHDATE Month/Day/Year / /	3. SEX	4. MEDICARE Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No ID#:	5. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # <input type="checkbox"/> No Date Applied / /
6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> NF <input type="checkbox"/> Care Home <input type="checkbox"/> Other				7. PROVIDER I.D. NO.	
8. ATTENDING PHYSICIAN (Last Name, First Name, Middle Initial) Phone: (808) Fax: (808)			9. CONTACT PERSON (Last Name, First Name, AND Title) Phone: (808) Fax: (808)		
10. RETURN FORM TO: Phone: (808) Fax: (808)			<input type="checkbox"/> VIA FAX (Type Fax Number Below) <input type="checkbox"/> BY MAIL (Type Address Below) Mail:		
11. REFERRAL INFORMATION (Completed by Referring Party) A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other B. RESPONSIBLE PERSON'S NAME (Last, First, M.I.) Name: Relationship: Phone: (808) Fax: (808) C. Language <input type="checkbox"/> English <input type="checkbox"/> Other			12. ASSESSMENT INFORMATION (Completed by RN or Physician) A. ASSESSMENT DATE / / B. ASSESSOR'S NAME (Last, First, M.I.) Name: Title: Signature _____ Phone: (808) Fax: (808)		
13. REQUESTING (Check all that apply) Expected Placement Date: / / <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Subacute I <input type="checkbox"/> Subacute II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlist <input type="checkbox"/> Subacute <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home & Community Based Services (HCBS) <input type="checkbox"/> NHWW <input type="checkbox"/> RACCP 1 <input type="checkbox"/> RACCP 2 <input type="checkbox"/> HCCP <input type="checkbox"/> PACE Program HCBS Option Counseling provided: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO: explain: If YES, by whom: Name Title: Independent Living (IL) service/material provided: <input type="checkbox"/> Yes <input type="checkbox"/> No					
14. MEDICAL NECESSITY / LEVEL OF CARE ACTION - DO NOT COMPLETE					
LEVEL OF CARE APPROVAL: <input type="checkbox"/> Subacute Level I <input type="checkbox"/> Subacute Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlisted Subacute <input type="checkbox"/> Acute Waitlisted SNF <input type="checkbox"/> Acute Waitlisted ICF <input type="checkbox"/> Hospice - NF			EFFECTIVE DATE: _____ LENGTH OF APPROVAL: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other - Specify: _____ to _____		
SETTING APPROVAL: <input type="checkbox"/> Home and Community-Based Services <input type="checkbox"/> Nursing Home Without Walls (NHWW) <input type="checkbox"/> Residential Alternatives Community Care Program (RACCP) Level I _____ Level 2 _____ <input type="checkbox"/> HIV Community Care Program (HCCP) <input type="checkbox"/> PACE Program <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home <input type="checkbox"/> Extended Care ARCH <input type="checkbox"/> Other _____ Comments: _____ _____ _____ <input type="checkbox"/> DEFERRED: <input type="checkbox"/> New 1147 Needed. <input type="checkbox"/> Other. Reason: _____ <input type="checkbox"/> DENIED					
NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE. DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____					

STATE OF HAWAII
Level of Care (LOC) Evaluation

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type)

<p>1. NAME (Last, First, Middle Initial)</p>	<p>2. BIRTHDATE / /</p>
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3. **FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS**

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY:

SECONDARY:

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XIV**.

III. VISION / HEARING / SPEECH:

[0] ☐ a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech

[1] ☐ b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech

[2] ☐ c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:

[0] ☐ a. Adequately communicates needs/wants

[1] ☐ b. Has difficulty communicating needs/wants

[2] ☐ c. Unable to communicate needs/wants

V. MEMORY:

[0] ☐ a. Normal or minimal impairment of memory

[1] ☐ b. Problem with [] long-term or [] short-term memory.

[2] ☐ c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS/BEHAVIOR: (refer to instructions)

[0] ☐ a. Oriented (mentally alert and aware of surroundings).

[1] ☐ b. Disoriented (partially or intermittently; requires supervision).

[2] ☐ c. Disoriented and/or disruptive.

[3] ☐ d. Aggressive and/or abusive.

[4] ☐ e. Wanders at ☐ Day ☐ Night ☐ Both, or ☐ in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:

[0] ☐ a. Independent with or without an assistive device.

[1] ☐ b. Feeds self but needs help with meal preparation.

[2] ☐ c. Needs supervision or assistance with feeding.

[4] ☐ d. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:

[0] ☐ a. Independent with or without a device.

[2] ☐ b. Transfers with minimal /stand-by help of another person.

[3] ☐ c. Transfers with supervision and physical assistance of another person.

[4] ☐ d. Does not assist in transfer or is bedfast.

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:
Attach additional sheet if more space is needed.

IX. MOBILITY / AMBULATION: (refer to instructions)

[0] ☐ a. Independently mobile with or without device

[1] ☐ b. Ambulates with or without device but unsteady / subject to falls.

[2] ☐ c. Able to walk/be mobile with minimal assistance

[3] ☐ d. Able to walk/be mobile with one assist.

[4] ☐ e. Able to walk/be mobile with more than one assist.

[5] ☐ f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:

[0] ☐ a. Continent

[1] ☐ b. Continent with cues.

[2] ☐ c. Incontinent (at least once daily).

[3] ☐ d. Incontinent (more than once daily, # of times _____).

XI. BLADDER FUNCTION / CONTINENCE:

[0] ☐ a. Continent

[1] ☐ b. Continent with cues.

[2] ☐ c. Incontinent (at least once daily).

[3] ☐ d. Incontinent (more than once daily, # of times _____).

XII. BATHING:

[0] ☐ a. Independent bathing.

[1] ☐ b. Unable to safely bathe without minimal assistance and supervision.

[3] ☐ c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:

[0] ☐ a. Appropriate and independent dressing, undressing and grooming.

[1] ☐ b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).

[2] ☐ c. Physical assistance needed on a regular basis.

[3] ☐ d. Requires total help in dressing, undressing, and grooming.

XIV. TOTAL POINTS:

☐ Comatose = 30 points

Total Points Indicated:

XV. MEDICATIONS/TREATMENTS:
(List all Significant Medications, Dosage, Frequency, and mode)
Attach additional sheet if necessary

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STATE OF HAWAII
Level of Care (LOC) Evaluation

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1. NAME (TYPE Last, First, Middle Initial)

2. BIRTHDATE

/ /

XVII. **SKILLED PROCEDURES:** D = Daily Indicate number of times per day L = Less than once per day N = Not applicable / Never

- | D | L | N | |
|------------------------------|-----------------------------|--------------------------|--|
| # | ✓ | ✓ | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tracheostomy care/suctioning in ventilator dependent person. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tracheostomy care/suctioning in non-ventilator dependent person. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasopharyngeal suctioning in persons with no tracheostomy. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Total Parenteral Nutrition (TPN) {Specify number of hours per day.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Maintenance of peripheral/central IV lines. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IV Therapy {Specify agent & frequency.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Decubitus ulcers (Stage III and above). |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Instillation of medications via indwelling urinary catheters {Specify agent.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intermittent urinary catheterization. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IM/SQ Medications {Specify agent.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with administration of oral medications {Explain} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swallowing difficulties and/or choking. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. {Specify reason person at risk for aspiration.} |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complicating problems of patients on <input type="checkbox"/> renal dialysis, <input type="checkbox"/> chemotherapy, <input type="checkbox"/> radiation therapy, <input type="checkbox"/> with orthopedic traction.
(Check problem(s) and describe) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Behavioral problems related to neurological impairment. (Describe) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other {Specify condition and describe nursing intervention.} |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | | Therapeutic Diet (Describe) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | | Restorative Therapy (check therapy and submit/attach evaluation and treatment plan: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech |

XVIII. **SOCIAL SITUATION:**

A. Person can return home ☐ Yes ☐ No Residential setting can be considered as an alternative to facility? ☐ Yes ☐ No

B. If person has a home, caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver:

C. Caregiver name (PRINT Last, First, Middle Initial):

Name:

Relationship:

Address:

Phone: (808)

Fax: (808)

XIX. **COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:**

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/____

Physician's Name (TYPE): _____

APPENDIX R
EVALUATION PROCESS FOR DETERMINATION OF ELIGIBILITY FOR THE
BEHAVIORAL HEALTH MANAGED CARE (BHMC) PLAN FOR SERIOUSLY
MENTALLY ILL (SMI) ADULTS OR SERIOUSLY EMOTIONALLY DISTURBED (SED)
CHILDREN

1) INPATIENTS

a) Individuals on Oahu

If, after reviewing relevant clinical information, the QUEST plan or referring fee-for-service provider determines that a member meets the criteria for a Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), they should complete and fax to the MQD the referral form entitled Referral for Serious Mental Illness. This form is self-explanatory, must be completed entirely, and should be submitted at least two (2) working days before anticipated discharge to:

Medical Standards Branch (MSB)/MQD
ATTENTION: SMI Determinations
Fax #: 692-8131

If the patient is discharged in advance of his/her projected discharge date, please inform the MQD Psychiatric Consultant at 692-8115 and use the process described under "OUTPATIENTS."

b) Individuals on Neighbor Islands

Use the process described under "OUTPATIENTS".

2) OUTPATIENTS - The QUEST plans or referring provider should mail or fax to the MQD, the "Referral for SMI/SED" form, the forms for the assessment of Mental States and Functional Scales. In addition, to expedite the processing of SMI/SED referrals, it is asked that as much of the following information, as possible, be included:

- a) Personal history, family history, social history and history of drug use.
- b) Mental health history and educational history.
- c) History of past hospitalizations and other prior psychiatric care.
- d) Local hospital admission and discharge summaries (including medical and psychiatric histories and physical examinations).
- e) Most current psychiatric and psychological assessments to include pertinent history, behavioral observation and presentation, diagnostic impression, reports of psychological/psychiatric testing, Global Assessment of Functioning (GAF) scores and substance abuse information using ASAM placement criteria (if applicable).

- f) Pre-signed option letters for patients who are or have Medicaid or Medicaid/Medicare insurance. (Note: Patients having Medicare only, are not eligible for SMI services.)
- 3) For QUEST plans, the MQD expects that the Medical Directors of the plans will review and sign all referrals for SMI/SED and any information (such as the assessment of mental state and functional scales) which may have been completed by health plan staff. Thus, the MQD will not make a determination that a member is SMI/SED (if referred by the plan) without the signature of the plan's Medical Director. Referrals for fee-for-service recipients can be made by providers other than the QUEST plans but need to be signed by a psychiatrist or psychologist.
 - 4) The MQD's psychiatric consultant will make a decision based on the information submitted.
 - 5) The Referral Form with the MQD's decision will be returned to the referring provider in most cases within seven (7) business days and not more than 30 days after receipt. The MQD makes one of the following four determinations:
 - a) SMI/SED - yes, full acceptance
 - b) Provisional SMI/SED - yes, provisional acceptance for limited period
 - c) SMI/SED – no
 - d) Additional Information Needed
 - 6) Provisional SMI/SED are those individuals who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.
 - 7) If the member is determined to be SMI/SED or provisional SMI/SED, the BHMC plan will receive a copy of all pertinent information submitted by the referring provider. In addition, the MQD's Enrollment Call Center will be notified to add the member's eligibility status to the member's eligibility file.
 - 8) If a member was not determined to be SMI/SED or if additional information is needed, the MQD will indicate the reason for this decision or the additional information needed on the referral form.
 - 9) After a referral has been submitted to the MQD and before the referring provider is notified of a decision, the referring provider shall update the MQD in situations including but not limited to the following:
 - a) The patient was admitted to the hospital.
 - b) The patient has an urgent need for behavioral health managed care services.
 - c) The referring provider has not received a determination seven (7) working days or more after submission of the referral.

Additional clarification which applies to both INPATIENTS and OUTPATIENTS:

- 1) If no records of prior hospitalizations are available, outpatient treatment services will be considered by the MQD's Psychiatric consultant in determining whether a member has an SMI/SED diagnosis. The following criteria will be used for the determination: Treatment for at least 6 months or must have a 6 month minimal expected duration, or must have a combined present and expected duration of 6 months.
- 2) Those members with a qualifying condition will be accepted provisionally into the behavioral health managed care plan for six months to allow for a complete assessment and intensive case management. A case review by the BHMC will begin four months after enrollment for members in this category. Once an SMI/SED diagnosis is established the member will be changed to an SMI/SED category. If the member does not have an SMI/SED diagnosis the member will be disenrolled from the behavioral health managed care plan. It is the responsibility of the referring provider to determine the continued treatment needs of those recipients determined not to have an SMI/SED diagnosis and is in treatment for substance abuse at the time of disenrollment.
- 3) Do not refer the following types of members as they **DO NOT** meet **SMI/SED** requirements:
 - a) Adults with SMI/SED diagnosis or who (in the absence of a diagnosis) have documentation of displaying SMI/SED symptoms for less than a combined and expected duration of at least 6 months.
 - b) Adults whose serious mental illness is not expected to last more than 6 months.
 - c) Adults with substance abuse diagnosis(es) only and NO independent psychiatric diagnosis that would otherwise qualify for SMI/SED consideration. Referrals can be made for those adults with a substance abuse diagnosis and a probable SMI/SED diagnosis which is unclear due to the patients' recent and sustained substance abuse.
 - d) Adults with psychiatric diagnosis(es) and developmental disabilities (DD)/mental retardation (MR) (other than mild DD/MR).
 - e) Patients with SMI/SED diagnosis(es) who are functioning well in the community.
 - f) Patients who do not have Medicaid insurance.
- 4) To expedite processing, the MQD will return only the referral form to the QUEST plan or Medicaid provider. If a provider wishes to have a determination reconsidered, all applicable information should be resubmitted. A decision on the reconsideration will be rendered within seven (7) working days of receipt in most cases and as stated in the RFP, not more than 30 days after receipt.
- 5) If a provider questions a determination, he/she should contact the MQD psychiatric consultant at 692-8115.

- 6) Other individuals such as psychiatrists and psychologists can also make referrals for SMI/SED evaluation.
- 7) If the referring provider needs clarification or has questions on SMI/SED referrals, contact the Medical Standards Branch at 692-8105.